

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corner pagina. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma or event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	6	8	6	5
										REG. NO.						
1. FOR STATE REGISTRAR			LAST			2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR			
(TYPE OR PRINT)			Alexander Sr.			October				23	1981	11:00	PM			
1. DECEASED NAME			FIRST		MIDDLE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
(TYPE OR PRINT)			David		Irvin		July 27 1911				70		YRS.		MONTHS DAYS HOURS MIN.	
3. SEX			4. RACE			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH						
Male			White							Kent County						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
Maryland			USA			Kent and Queen Anne's Hospital				Retired Construction Worker						
10. CITY OR TOWN OF DEATH			13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Chestertown			Maryland				Kent		Millington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 349 A			
14. FATHER'S NAME			FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			16. MIDDLE			LAST	
James			NMN				Alexander		Bessie			NMN			Seward	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			220-01-3153			Hospital Records, Chestertown, Maryland										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>										1 wk						
1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Nephroma to</i> <i>Lungs and brain</i>						
DUE TO, OR AS A CONSEQUENCE OF (c)										10 yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Cardio Vascular disease - CHF</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from October 14, 19 81, to October 23, 19 81, that (I) (we) last saw the deceased alive on October 23, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED						
22b. SIGNATURE <i>Michael P. Bey</i> MD										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael P. Bey										22e. ADDRESS Chestertown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10/26/81			23c. NAME OF CEMETERY OR CREMATORIAL Millington Cem.			23d. LOCATION CITY OR TOWN Millington, Kent, MD			23e. COUNTY STATE				
24. FUNERAL DIRECTOR Edw. Fellows and Son Millington MD 21651										25d. DATE REC'D. BY REGISTRAR NOV 2 1981		25e. REGISTRAR'S SIGNATURE <i>Jan Nathan</i>				
BP _____																
DHMH-16 30M 2/80 (VRA 15, 4)																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 6 3 6 6			
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE	LAST		REG. NO.			
		EDNA EUNICE ALLEN								Oct. 9, 1981			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR 4:30 A				
female		white		8/13/1889 1899			1921 82 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Kent Co.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN				
8b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9a CITY OR TOWN OF DEATH Magnolia Hall Nursing Ctr.		10 CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Magnolia Hall Nursing Ctr.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife and Steno.		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Md.		14 COUNTY Kent		13b CITY OR TOWN Kennedyville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS RFD # 1				
14 FATHER'S NAME FIRST not known		MIDDLE		15 IS MOTHER'S MAIDEN NAME FIRST not known			16b SOCIAL SECURITY NO 216 44 3507		17 INFORMANT Son Lloyd Allen Kennedyville, Md.		ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ca pancreas</i> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION 8/7/81		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Diagnosis - to relieve obstruction</i>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a I certify that (1) (this hospital) attended the deceased from <u>3</u> , 19 <u>78</u> , to <u>10/9</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>10/8</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.												22c. DATE SIGNED 10/9/81	
22b SIGNATURE <i>C Gottfried Baumann</i>		22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10/9/81								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) C Gottfried Baumann		22f ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/10/81		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.			23d. LOCATION CITY OR TOWN Brentwood, Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Willis Wells		ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR OCT 13 1981		25b. REGISTRAR'S SIGNATURE James Jan Wathen						

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified before death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81 26861		
										REG. NO.		
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT) Catherine NMN Barnes				2a. DATE OF DEATH Oct. 17, 1981				2b. HOUR 8:14P M			
3. SEX Female	4. RACE White		5. DATE OF BIRTH March 27, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS MONTHS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County		MD.					
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired teacher		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland					13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RR 2 Box 220	
14. FATHER'S NAME FIRST Edgar MIDDLE Josiah LAST Watson					15. MOTHER'S MAIDEN NAME FIRST Priscie MIDDLE Decoursey LAST Maslin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-26-2766		17. INFORMANT Hospital Records		ADDRESS Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Route Renal Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours		
5860 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <i>Hypoxic Shock</i>										72 hours		
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Aspiration pneumonia, Diabetes mellitus, ASCVD, HBO</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>October 15, 1981</u> to <u>October 17, 1981</u> , that (I) (we) last saw the deceased alive on <u>October 17, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 10/19/81		
22b. SIGNATURE <i>Susan K Ross, MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan K. Ross, M.D.		22e. ADDRESS Chestertown Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/20/81		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION CITY OR TOWN Chestertown, Md.		23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>Willis Wells</i>		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR OCT 20 1981		25b. REGISTRAR'S SIGNATURE <i>Chances Jan Farthen</i>						
DHMH-16 30M 2/80 (VRA 15, 4)												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 6 8 6 8				
												REG. NO.				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A 12:23				
			Catherine M Bramble						Oct. 9, 1981							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN				
female		white		8/29/1913			68 Yrs.			YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Md.		USA					Kent									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Chestertown		At Home Byford Hgts.					R.N.			Nursing						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Byford Hgts.							
14. FATHER'S NAME FIRST unk.		MIDDLE Wilson		15. MOTHER'S MAIDEN NAME FIRST Vertie			MIDDLE Cleinger		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 265 03 6346		17. INFORMANT THM Bramble			ADDRESS Chestertown, Md.		Husband							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1629 Oat cell carcinoma of right lung																
DUE TO, OR AS A CONSEQUENCE OF (b)																
Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause, if any (c)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from 10-9-81 to 10-9-81, that (1) (we) last saw the deceased alive on 10-9-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					6 27 57			10-9		81						
22b. SIGNATURE Robert W. Farr					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-9-81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS Chestertown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/11/81			23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Willy Wells		ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR OCT 13 1981			25b. REGISTRAR'S SIGNATURE James Van Gorder								
BP _____																
DHMH-16 20M (VRA 15, 4) 7/7B																

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. (PM 3) PRIORITY TO BURIAL CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH26869
REG. NO.
2b. HOUR
1:00 PM

1- STATE REGISTRAR		LAST										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST				2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR 1:00 PM		
ALICE				CANN						10/26/81 19					2b. HOUR 1:00 PM		
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9/3/1888		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 10/26/81 19		2d. HOUR 4:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED X		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Kent							
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hosp.		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY											
13. STATE Md.		14. COUNTY Kent (Edesville		15. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD # 2									
14. FATHER'S NAME FIRST Samuel Murray		15. MOTHER'S MAIDEN NAME Florence Warner															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217 30 8440		17. INFORMANT Enoch Smith		RFD ADDRESS # 2											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 78902		IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		Smoke Inhalation, Possible CO Poisoning												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(b) DUE TO, OR AS A CONSEQUENCE OF															
		(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Found dead in house filled of fumes and soot.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		CITY OR TOWN		CITY OR TOWN		CITY OR TOWN		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
22b. TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER																	
22c. DATE SIGNED 10/26/81																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/81		23c. NAME OF CEMETERY OR CREMATORIUM Sharptown Cemetery		23d. LOCATION CITY OR TOWN Rock Hall Md.		CITY OR TOWN		CITY OR TOWN		CITY OR TOWN		CITY OR TOWN		STATE	
24. FUNERAL DIRECTOR NAME James Perkins		25a. DATE REC'D. BY REGISTRAR NOV 2 1981		25b. REGISTRAR'S SIGNATURE James J. Harten													

and mostly of silicate and silicate clays

7000 feet sand to pebbles over alluvial muds

varied

PKM

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6 8 7 0
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours.

1. DECEASED-NAME (Type or print)	First <i>JULIA</i>	Middle <i>WOODALL</i>	Last <i>CRYIKSHANK</i>	2a. DATE OF DEATH Month <i>9</i>	2b. HOUR Year <i>30 81 5:20 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Feb 26, 1886</i>		6. AGE (In years last birthday) <i>95</i>	IF UND. 1 YEAR MONTHS IF UND. 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>KENT</i>	Md.	
10. CITY OR TOWN OF DEATH <i>CHESTERTOWN</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MACENOCIA HOSP. N.H.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>KENT</i>	13c. CITY OR TOWN <i>CHESTERTOWN</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>206 WASHINGTON AVE.</i>	
14. FATHER'S NAME First <i>ANDREW</i>	Middle <i>WASHINGTON</i>	Last <i>Woodall</i>	15. MOTHER'S MAIDEN NAME First <i>ALICE</i>	Middle <i>IRVINE</i>	Last <i>GRIFFITH</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>212-74-7963</i>	17. INFORMANT <i>P.O. Box 223</i>	Approximate Interval Between Onset and Death <i>10 years</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCVS</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>4292</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (c) <i>DUE TO, OR AS A CONSEQUENCE OF</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION <i>2/29</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNFORTUNATELY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. , Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>3-7</i>	City or Town <i>Chestertown</i>	County <i>Md.</i>	State
22a. I certify that (I) <i>A.C. Dick</i> attended the deceased from <i>3-7</i> , 1952 to <i>Sept. 30, 1981</i> , that (I) <i>()</i> last saw the deceased alive on <i>9-30 1981</i> , and that in (my) <i>()</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>()</i> (did) <i>()</i> view the body after death.					
22b. SIGNATURE <i>A.C. Dick</i>	DEGREE <i>Attending Phys.</i>	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-1-81</i>
22d. PHYSICIAN'S NAME (Type) <i>A.C. Dick</i>	22e. ADDRESS <i>Chestertown, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>10-3-81</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Sudlersville Cem.</i>	23d. LOCATION (City or Town) <i>Sudlersville</i>	(County) <i>Q.H.</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Marvin V. Willis Jr.</i>	ADDRESS <i>Chestertown, Md.</i>	25a. REC'D. BY REGISTRAR <i>OCT 13 1981</i>	25b. REGISTRAR'S SIGNATURE <i>James Jean Parker</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 81 26871					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR				
Alexander Francis Dlugoborski Sr.						October 23, 1981	400p M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Male		Whtie		June, 12, 1910		71		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		U.S.A.				Kent County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent and Queen Anne's Hospital		Retired-Construction worker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		Sharp Street	
Maryland		Kent County		Rock Hall							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Francis		NMN		Dlugoborski		Pauline		NMN		Redyk	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no		217-36-1205		Hospital Records- Chestertown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Acute Leecharia					
2080 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.						DUE TO, OR AS A CONSEQUENCE OF (b) - possible pneumonia.					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from October 8, 1981, to October 23, 1981, that (I) (we) last saw the deceased alive on October 23, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Patrick A. Molony, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED OCT 29 1981					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Chestertown, Maryland 21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-26-81		23c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		23d. LOCATION CITY OR TOWN Rock Hall		COUNTY Kent		STATE Maryland	
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home; Chester, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 29 1981		25b. REGISTRAR'S SIGNATURE James Jean Warner					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

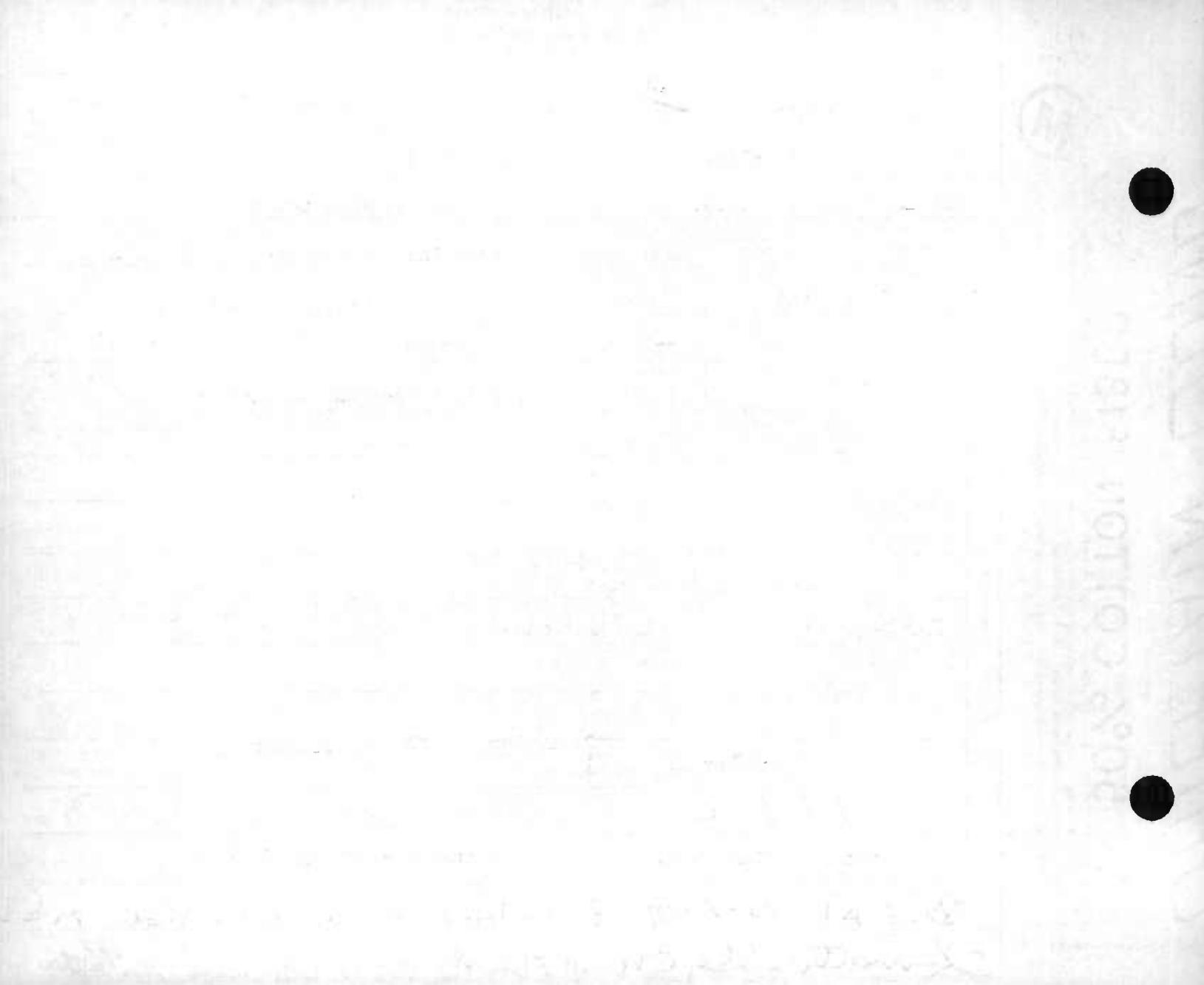
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8126872																	
												REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR											
(Geo. L.) Roy			NMN			Goodman						October 24, 1981						6:10 P M											
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS											
Male			White			October 22, 1896			85			YRS.			MONTHS DAYS			HOURS MIN.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Maryland			U.S.A.									Kent County			Chestertown			Kent & Queen Anne's Hospital			Salesman & Ret Farmer								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Maryland			Kent			Lynch			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			P.O. Box 145			William			Sadie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
Yes			WW I			218-20-5340			Hospital Records			Chestertown, Maryland			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Pneumonia											
2030			DUE TO, OR AS A CONSEQUENCE OF (b) Acute myelogenous Leukemia			DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Myeloma																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												CHF 2+ AS CVD																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE														
22a. I certify that (1) (this hospital) attended the deceased from October 24, 1981, to October 24, 1981, that (1) (we) last saw the deceased alive on October 24, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												22b. SIGNATURE M. P. Bey			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/25/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Chester Cemetery			Chester Cemetary			Chester Cemetary			Chester Cemetary			Chester Cemetary			Chester Cemetary								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Burial			10/26/81						Chester Cemetery			Chester, Md.						Oct 27 1981			Jean Harten								
24. FUNERAL DIRECTOR NAME			ADDRESS			Chestertown, Md.																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	8 1 2 6 8 7 3						
1. FOR STATE REGISTRAR			FIRST Louise			MIDDLE NMN			LAST Hackett			2a. DATE OF DEATH	MONTH October	DAY 2	YEAR 1981	2b. HOUR 8:25	A M
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH December			YEAR 1924			6. AGE (IN YEARS LAST BIRTHDAY)	56	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County								
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY --								
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Worton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rte. #1 Box 101					
14. FATHER'S NAME FIRST Abraham			MIDDLE NMN			LAST Robinson			15. MOTHER'S MAIDEN NAME FIRST Carmeta			MIDDLE NMN			LAST Black		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. -			17. INFORMANT			ADDRESS 21620 Hospital Records-Chestertown, Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Metastatic Carcinoma																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bowel Obstruction																	
19a. DATE OF OPERATION 23 Sept 81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from September 8, 1981, to October 2, 1981, that (I) (we) last saw the deceased alive on October 2, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Robert Schreiber, M.D.			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 20 Oct 81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Schreiber, M.D.			22e. ADDRESS Chestertown, Maryland 21620														
23a. BURIAL, CREMATION, REMOVAL 10-7-81			23b. DATE 10-7-81			23c. NAME OF CEMETERY OR CREMATORIAL FOUNTAIN CEM			23d. LOCATION CITY OR TOWN Worton			COUNTY Kent					
24. FUNERAL DIRECTOR Name Dorothy Waller, CHESTERTOWN			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 8 1981			25b. REGISTRAR'S SIGNATURE Doris Jan Nathan								



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

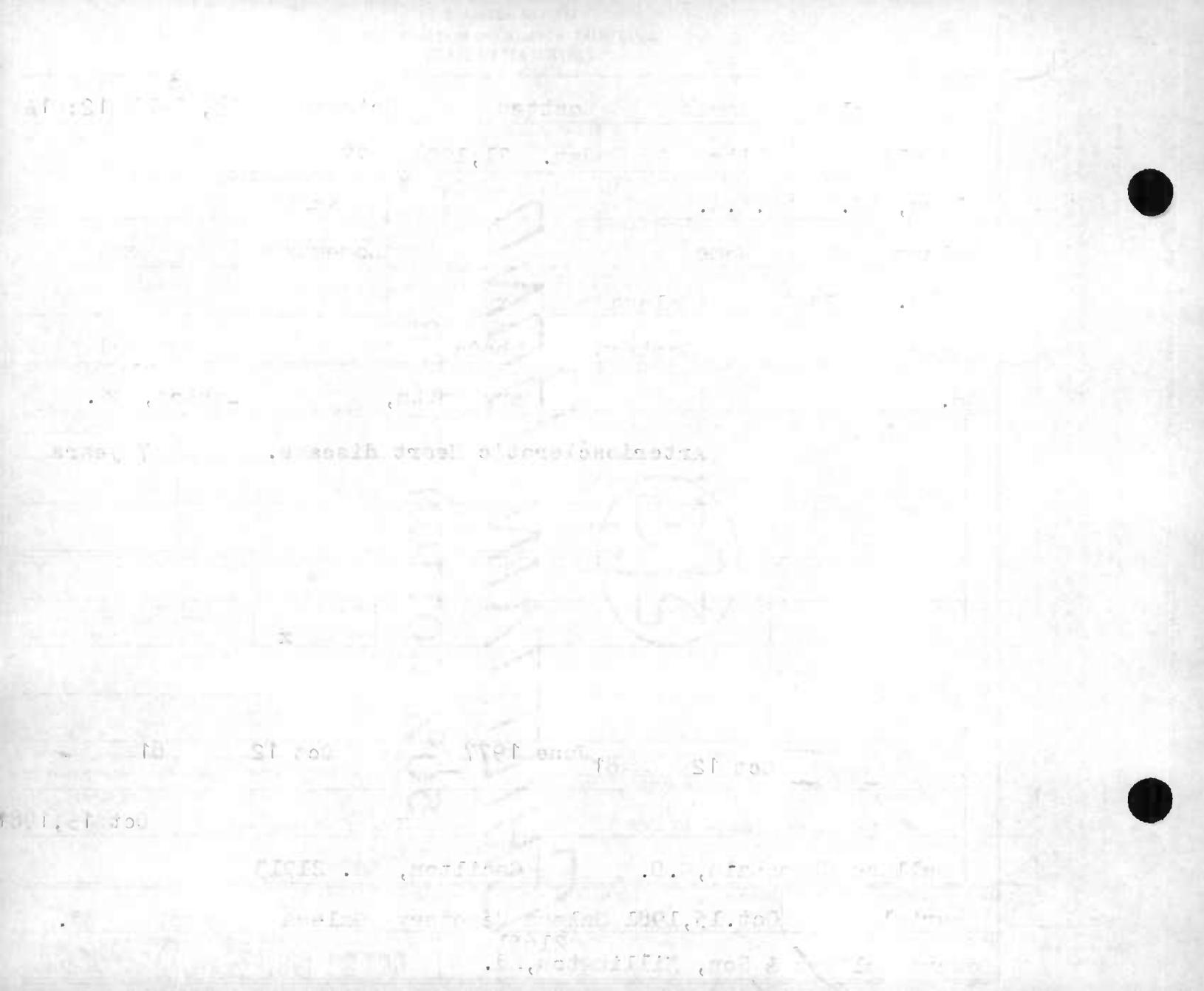
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 1 2 6 8 7 4				
						REG. NO.				
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	Edna	Elizabeth	Holden	October 6, 1981			10:12 A			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	white	December 16, 1909			71					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland	U.S.A.				Kent County					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown	Kent & Queen Anne's Hospital, Inc.			Housewife						
13a. STATE Maryland	13b. COUNTY Queen Anne	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 133				
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST					
William	Henry	Covey	Mary	Jane	Dyott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT			ADDRESS					
No	--	220-16-9671			Hospital Records-Chestertown, Maryland 21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months										
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from September 28, 1981, to October 6, 1981, that (I) () lost sow, the deceased alive on October 6, 1981, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did not) view the body after death.										
22b. SIGNATURE DEGREE										
Wayne D. Benjamin, M.D. ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22c. DATE SIGNED 10-6-81										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Chestertown, Maryland 21620							
Wayne D. Benjamin, M.D.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/8/81	23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.		STATE		
Burial										
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 10/8/81			25b. REGISTRAR'S SIGNATURE Jan Nathan					
H. Willis Wells										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	6	8	7	5		
1. FOR STATE REGISTRAR										REG. NO. 13, 1981								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH		MONTH	YEAR	2b. HOUR					
Selma Sarah Scotten									October		13	1981	12:01A					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female			White			Jan. 31, 1904			77		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.							
Galena, Md.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Galena			Home			Homemaker			Home									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Md.			Kent			Galena			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
James			Scotten			Rhoda					Mary Smith,		21629					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No.									Arteriosclerotic Heart disease.				7 years					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from June 1977, 19, to Oct 12, 19, 81, that (I) (we) lost saw the deceased alive on Oct 12, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.																		
22b. SIGNATURE Wallace Obenshain, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		Oct 15, 1981							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
Wallace Obenshain, M.D.			Cecilton, Md. 21913															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 15, 1981			23c. NAME OF CEMETERY OR CREMATORIY Galena Cemetery			23d. LOCATION CITY OR TOWN Galena		23e. COUNTY Kent		STATE Md.					
24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md.			ADDRESS 21651			25a. DATE REC'D. BY REGISTRAR OCT 21 1981			25b. REGISTRAR'S SIGNATURE Jan Nathan									

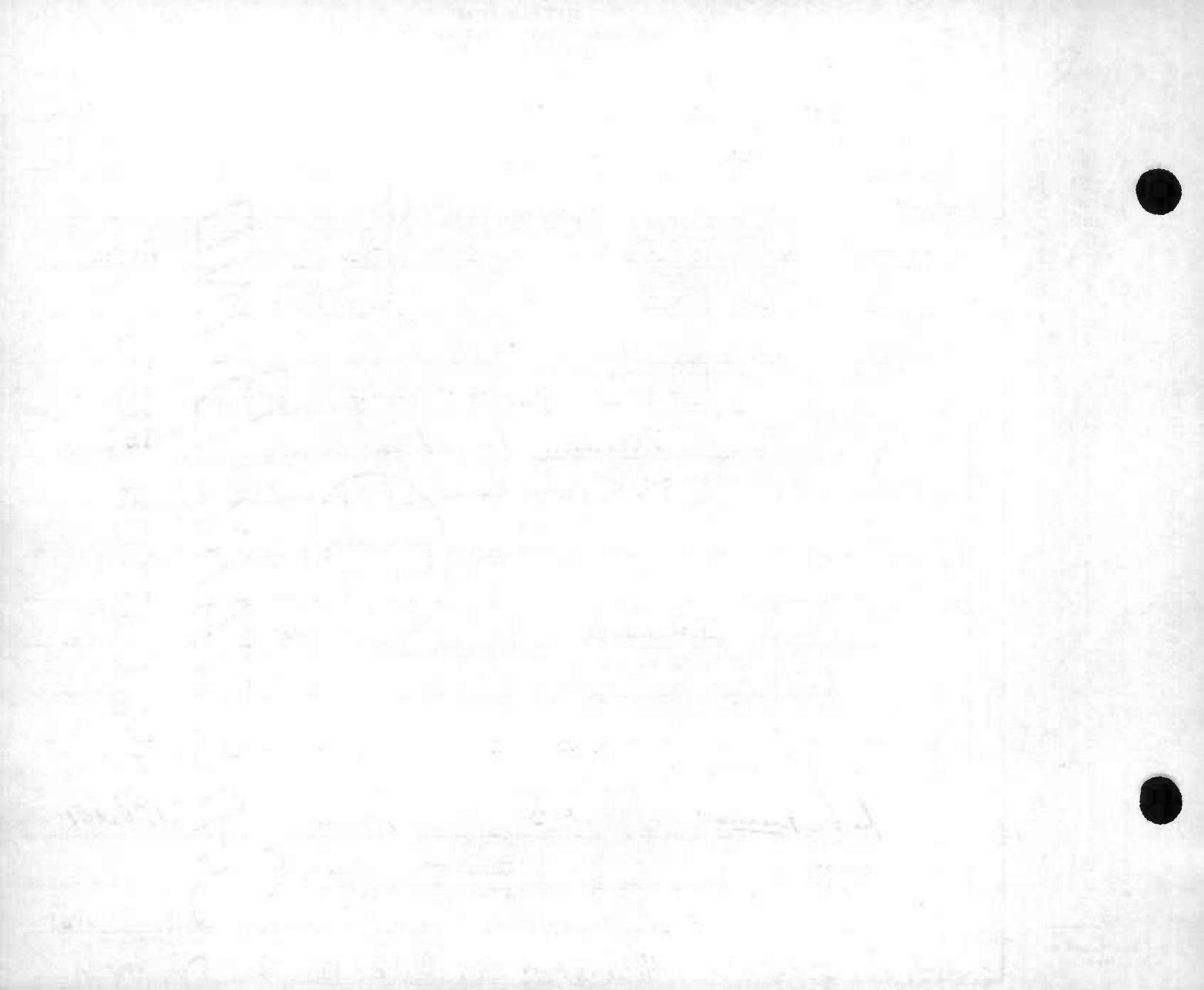


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 26876					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Howard			NMN	Short		October				15	1981	6:08 am					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
Male		White		February 14, 1909			72			YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		USA					Kent County										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Chestertown		Kent and Queen Anne's Hospital		Farm Hand			Farming										
13a. STATE MD COUNTY												13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland												Queen Anne's Millington				Rte. 1 Box 156	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Lizzie			FIRST	MIDDLE	LAST							
George			NMN	Short	Unknown					Carey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			217-28-3878			Hospital Records, Chestertown, Maryland			21620								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991												12 hours					
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer To Liver																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Jaundice			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from October 14, 1981, to October 15, 1981, that (I) (we) last saw the deceased alive on October 15, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.												22b. SIGNATURE Robert Schreiber					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22g. DATE SIGNED 15 Oct 81					
Robert Schreiber			Chestertown, Maryland 21620														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 18, 81			23c. NAME OF CEMETERY OR CREMATORIAL Crumpton Cemetery			23d. LOCATION CITY OR TOWN Crumpton			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME Gary B. Fellous			ADDRESS Millington Md			25a. DATE REC'D. BY REGISTRAR OCT 23 1981			25b. REGISTRAR'S SIGNATURE John W. ...								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

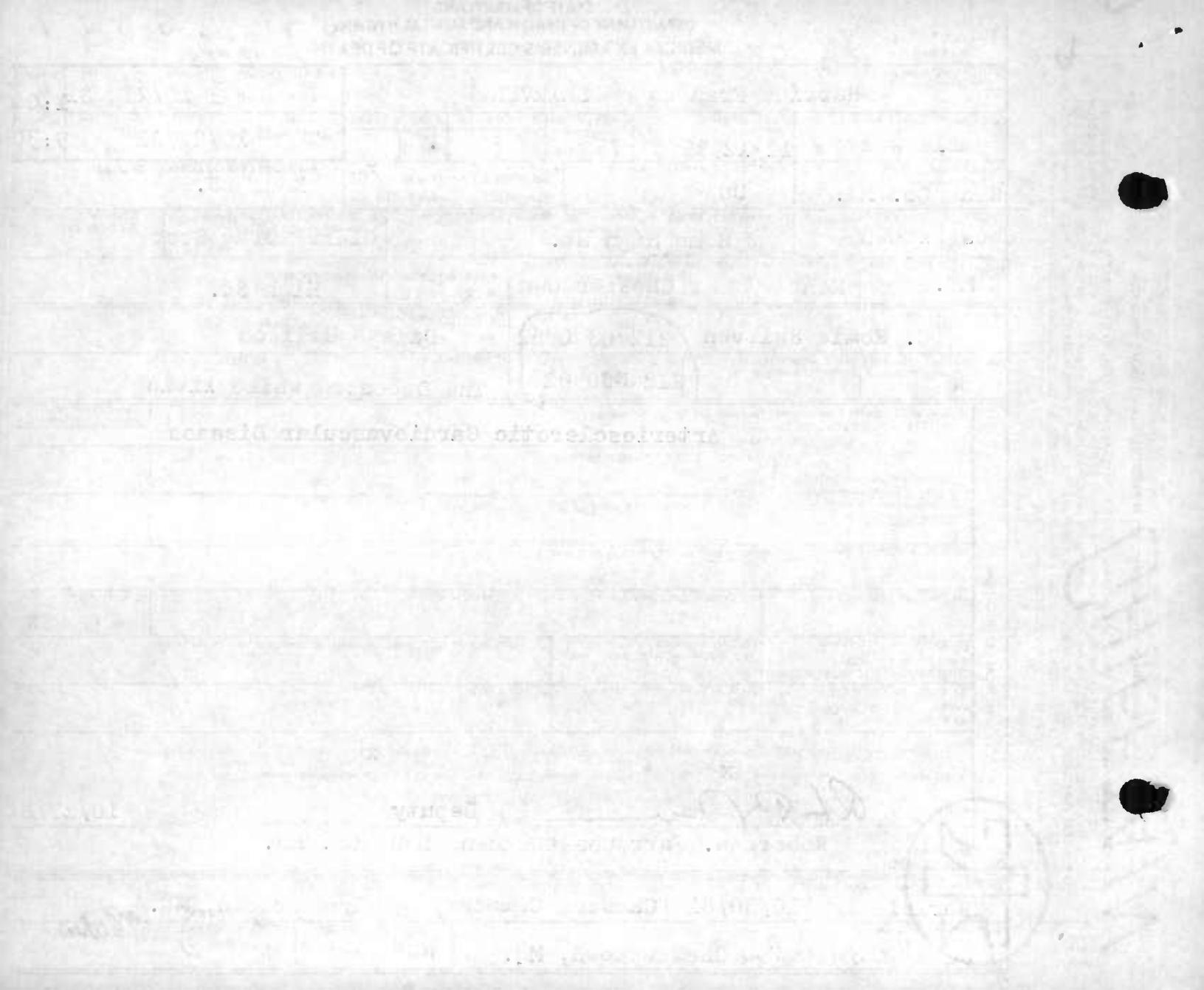
MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26871

1- STATE REGISTRAR		2a. DATE KNOWN <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 10/27/19 81										2b. HOU A 1:00			
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST				2c. DATE PRONOUNCED DEAD 10/27/81		2d. HOU A 9:30 M	
Harriet Frances SKIRVEN															
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2e. DATE PRONOUNCED DEAD 10/27/81			
female	white	12/12/1905			75			MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co.					
Kent Co. Md.		USA													
10. CITY OR TOWN OF DEATH Chesertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			At Home High St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
								Clerk		Drug Store					
13a. STATE Md.		13b. COUNTY Kent			13c. CITY OR TOWN Chesertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS High St.					
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
C. Romie Skirven					212 03 0962			Daisy Usilton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. 4292		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no		212 03 0962													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. 4292		19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input type="checkbox"/>		and in my opinion					
death resulted from:		Natural causes <input checked="" type="checkbox"/>			Accident <input type="checkbox"/>			Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		<u>Robert W. Farr</u>			M.D.			TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)		Robert W. Farr/Chestertown			Kent Co. Md.			ADDRESS				10/27/81			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 10/30/81			23c. NAME OF CEMETERY OR CREMATORIY Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR NOV 2 1981		25b. REGISTRAR'S SIGNATURE					
J. Willis Wells		Chestertown, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

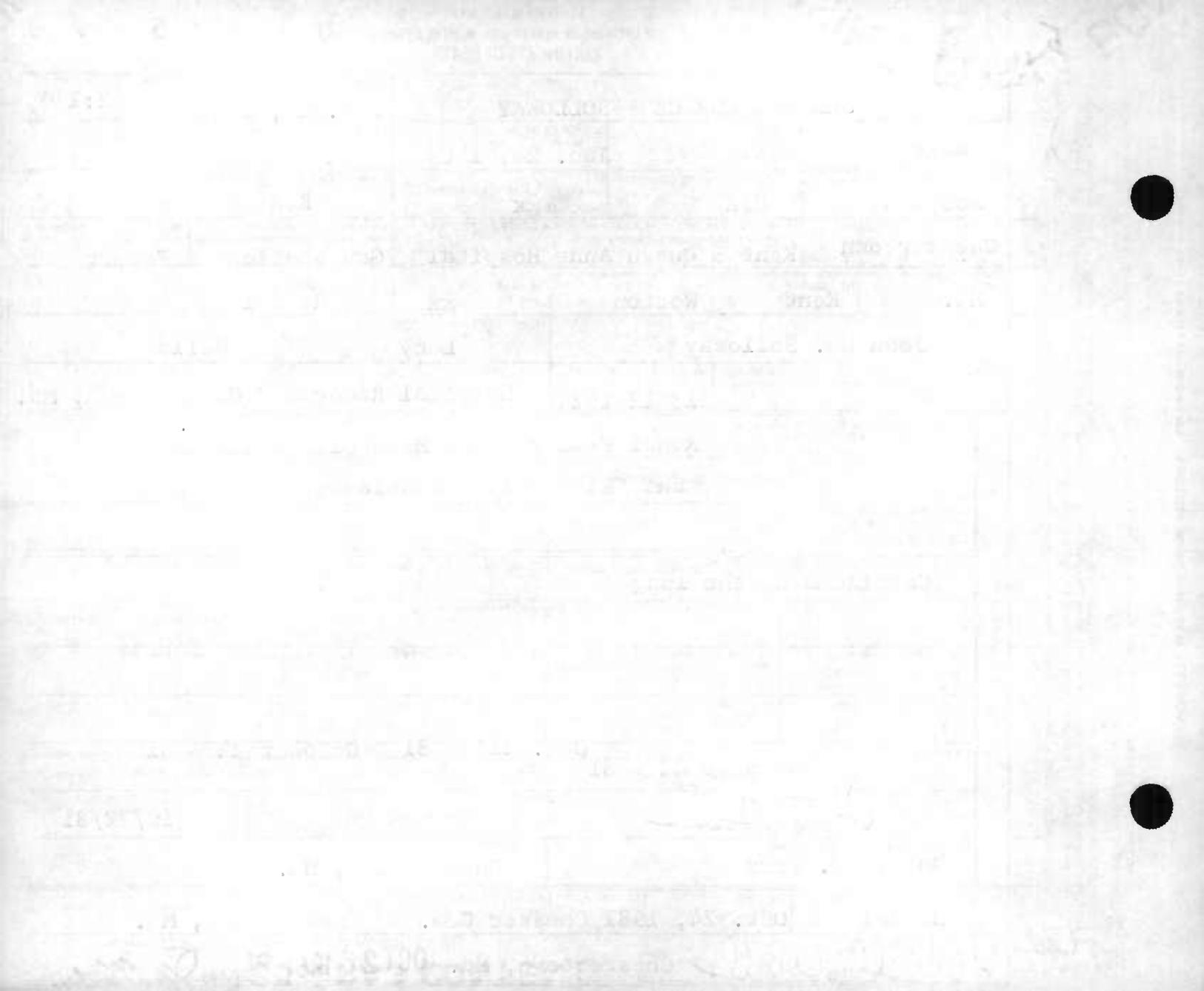
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 6 8 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
JAMES HORACE SOLLOWAY						Oct. 22, 1981				2:25A	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
				Jan. 24, 1909		72					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent		MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gas Station & Farmer		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt # 1			
14. FATHER'S NAME FIRST MIDDLE LAST John Wm. W. Solloway		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Wells									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 1 # YES, GIVE WAR OR DATES) 213 12 1924		17. INFORMANT Hospital Records		ADDRESS Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5860						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) and Electrolyte imbalance					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of the Lung											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from October 22, 1981, to October 22, 1981, that (I) (we) last saw the deceased alive on October 22, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert W. Farr</i>		DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/22/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr		22e. ADDRESS Chestertown, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 24, 1981 Chester Cem.		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR OCT 26 1981		25b. REGISTRAR'S SIGNATURE James Jan Walker					

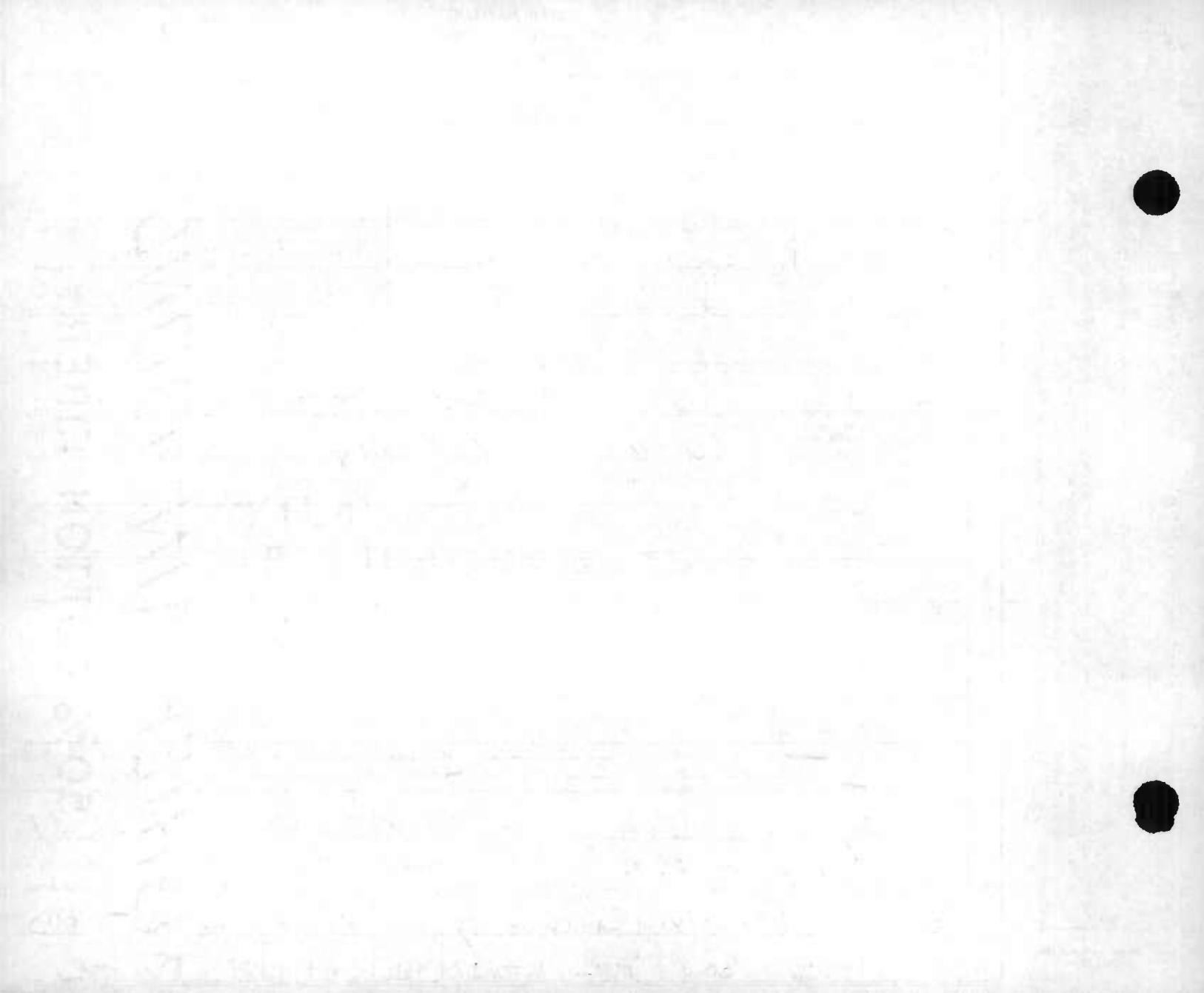


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8126879								
												REG. NO.								
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Frances			MIDDLE NMN			LAST Stauffer			20. DATE OF DEATH MONTH October 19, 1981			2b. HOUR 9:50PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH June			DAY 26			YEAR 1900			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.								
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Occupational Therapist			12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 306 Cedar Street								
14. FATHER'S NAME FIRST Paris			MIDDLE Becker			LAST Stauffer			15. MOTHER'S MAIDEN NAME FIRST Ann			MIDDLE Norris			LAST Buchert					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-6769			17. INFORMANT ADDRESS Hospital Records-Chestertown, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 Carcinoma of Ovary 18 weeks			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			(c)			DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from October 12, 1981, to October 19, 1981, that (I) (we) last saw the deceased alive on October 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not (did not) view the body after death.																				
22b. SIGNATURE Wayne D. Benjamin, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-22-81											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin, M.D.			22e. ADDRESS Chestertown, Md. 21620			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/23/81			23c. NAME OF CEMETERY OR CREMATORIAL Shrewsbury Cem			23d. LOCATION CITY OR TOWN Kennebunk COUNTY Kent STATE MD					
24. FUNERAL DIRECTOR NAME EDW. Fellows & Son			ADDRESS MILLINGTON MD			25a. DATE REC'D. BY REGISTRAR OCT 26 1981			25b. REGISTRAR'S SIGNATURE Frances F. K. Wadsworth											
DHMH-16 30M 2/80 (VRA 15, 4)																				



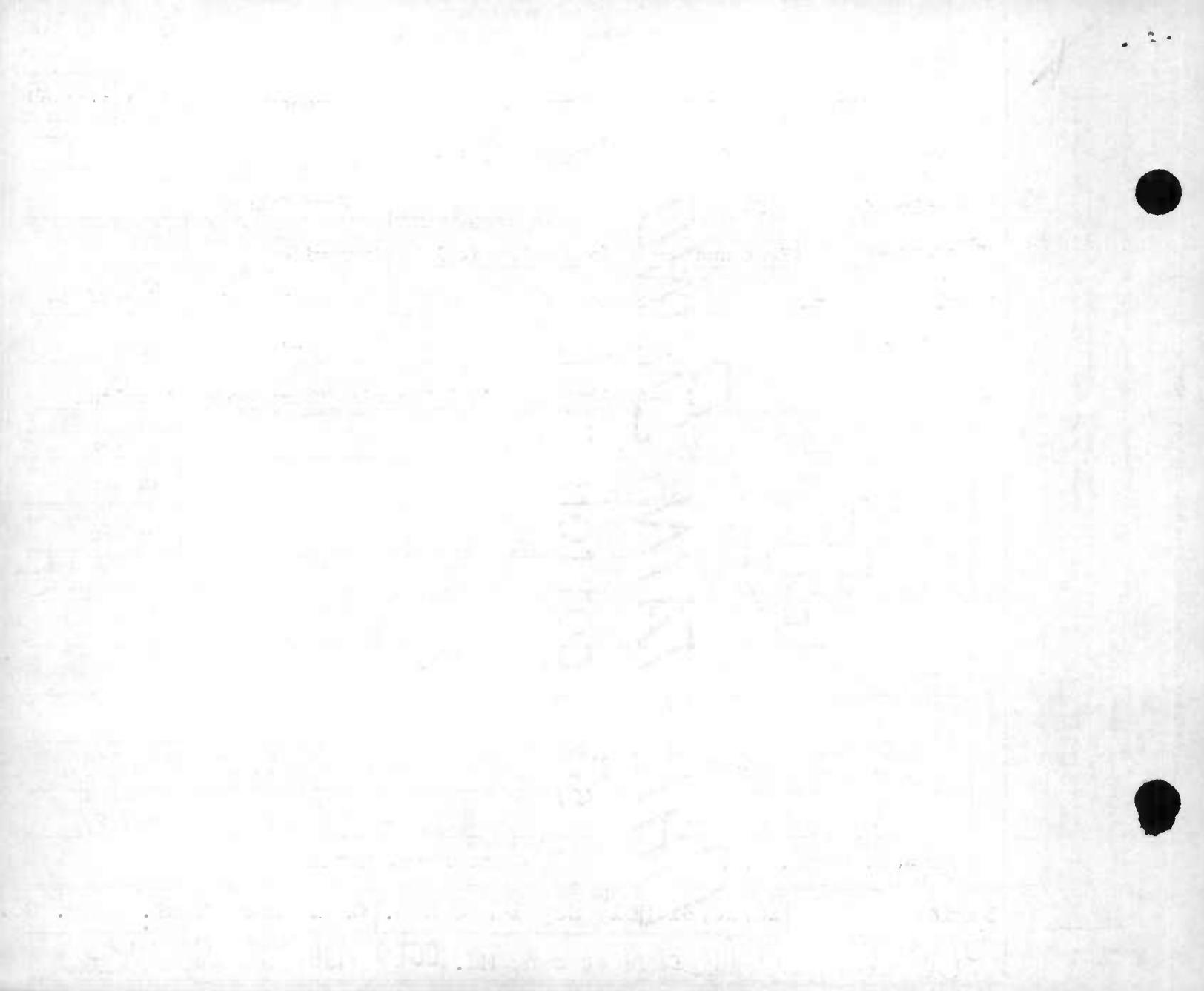
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	6	8	8	0	
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
Mary Frances Strasser						October 08, 1981			1:24 AM								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		March 08, 1911			70			YRS.		MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Pennsylvania		USA					Kent County										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Chestertown		Kent and Queen Anne's Hospital		Housewife													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Kent		Chestertown						Milbrook Road			RD # 4				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Martin		Jordon			Ann			Maria			Logan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS										
No		184-46-4488		Hospital Records, Chestertown, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH							
Acute renal failure 4275										24 hrs.							
DUE TO, OR AS A CONSEQUENCE OF (b) Shock										48 hrs							
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiopulmonary Arrest										48 hrs.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Acute liver failure, Probable D. flux intravascular coagulopathy, Aspiration Pneumonia, Ascites arrhythmia																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from October 5, 1981, to October 8, 1981, that (I) (we) last saw the deceased alive on October 8, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE DEGREE					22c. DATE SIGNED		
Susan K. Ross, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					10/18/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Susan K. Ross, M.D.		Chestertown, Maryland															
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10/10/81			23c. NAME OF CEMETERY OR CREMATORIUM Holy Sepulchre Cem.			23d. LOCATION Chestertown, Penns. Mont. Co.									
24. FUNERAL DIRECTOR NAME		ADDRESS			DATE REC'D. BY REGISTRAR OCT 9 1981			25b. REGISTRAR'S SIGNATURE Charles Jan Harten									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 6 8 8 1	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
OLIN ARTHUR TAYLOR						Oct. 7, 1981			12:30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
male		white		MONTH DAY YEAR			61			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Kent Co. Md.		USA					Kent Co.			MONTHS DAYS HOURS MIN	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Chestertown		at home High St.								12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Md.		Kent		Chestertown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		High St.		
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME						
Alexander Taylor					Charlotte Reed						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		220 12 1827					Charlotte Slagle - Chestertown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease											
4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Obstructive Pulmonary Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-6, 19 61, to 10-7, 19 81, that (I) (we) last saw the deceased alive on 10-7, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
Robert W. Farr								10/9/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Robert W. Farr					Chestertown, Md. 21620						
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE			
10/10/81					Chester Cemetery			Chestertown, Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Willis Wells		Chestertown, Md.			Oct. 9, 1981			D. W. Wells			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 6 8 8 2							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
William Andrew									TOSICK			Oct. 14, 1981				1 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			
male		white		Oct. 5, 1912			69			Wilm. Del			USA			Kent			
MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown		At Home Chesmar Est.												Radiologist			Hospital		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Md.		Kent		Chestertown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Chesmar Est.									
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
John Tocik											Veronica Gongal								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			12. INFORMANT			16c. ADDRESS			16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
yes		WW 2			221 05 1286			Monique Tosick			Chestertown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART 1 DEATH WAS CAUSED BY																			
IMMEDIATE CAUSE (a) <u>Acute hypocalcical infarction (probable)</u>																			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular disease clu</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
			HOUR A.M. MONTH DAY YEAR																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13/81</u> to <u>10/14/81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>10/13/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Patrick A. Molony</u> DEGREE <u>MD</u>																			
22c. ADDRESS <u>Chestertown, Md. 21620</u>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION										
Burial			10/17/81			Veterans Eastern Shore Cem.			CITY OR TOWN			COUNTY STATE							
24. FUNERAL DIRECTOR NAME <u>Willie Wells</u>			ADDRESS <u>Chestertown, Md.</u>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
						Oct 19 1981													

FOR
1 - STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
John Wesley Trew2a. DATE KNOWN
OF DEATH
ESTIMATED

MONTH

DAY

YEAR

7b. HOUR

Oct. 20 '81 8:30 A.

35
10. SEX
M4 RACE
W5. DATE OF BIRTH
MONTH DAY
8 136 AGE (IN YEARS)
YEAR
13 68 yrs.7 IF UNDER 1 YR.
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN2c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2d. HOUR

10-20 19 818:30 A.

10a. BIRTHPLACE
(STATE OR
FOREIGN COUNTRY)

Kent Co., Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED
✓ NEVER MARRIED
WIDOWED
DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

Kent

10b. CITY OR TOWN OF DEATH

Chestertown

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Quaker Neck, Chestertown Md12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

caretaker

12b. KIND OF BUSINESS
OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS

RD#3

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Joseph Simmons

Trew Sr.

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Lillian May

Hadaway

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

No

214-32-7228

17. INFORMANT

ADDRESS

Mary Reid Trew, RD3, Chestertown

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4100

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF

(b) Manner of death resembled Myocardial

DUE TO, OR AS A CONSEQUENCE OF

(c) Infarction

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes Mellitus

MEDICAL CERTIFICATION

18a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING OR

P.M. 19

CONTRIBUTING CAUSE OF DEATH

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATEWHILE NOT WHILE AT WORK AT WORK 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opiniondeath resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURETITLE (SPECIFY)
M.D. Deputy
MEDICAL EXAMINERDATE
SIGNED 10-22-81EXAMINER'S NAME
(TYPE OR PRINT)

Robert W. Farr, M.D. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIUM

COUNTY

STATE

Burial

10/23/81

Chester Cemetery, Chestertown, Kent, Md.

24. FUNERAL DIRECTOR

NAME

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Marna V. Williams, Jr.

'OCT 28 1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "DEATH" IN PENCIL. IN PENCIL, WRITE THE NAME OF THE MEDICAL EXAMINER ALONG WITH FORM FA-3, RETAIN PAGE 5 FOR YOUR FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FA-3, RETAIN PAGE 5 FOR YOUR FUNERAL DIRECTOR. PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME(5))
15M 7/76

1. Land and water

2. Soil and water

3. Soil and water

4. Soil and water

5. Soil and water

61
6 8 8 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 11 43 P.M.			
GILBERT LOREN WATSON II						10	3	81				
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE	AUG. 29, 1919			62 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
Conn.		U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			KENT						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
CHESTERTOWN		RD #3 Box 148			GOVERNMENT EMPLOYEE TRANSFERRED							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Md.		KENT	CHESTERTOWN			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RD #3 Box 148					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
CORNELIUS BUSHNELL WATSON					LOUISE EUGENIE SMITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO.			17. INFORMANT			Address RD #3 Box 148				
No		298-14-5122			MARIE LOUISE WATSON CHESTERTOWN, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>CHRONIC RESPIRATORY ARREST</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) <u>MULTIPLE MYELOMA</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
29					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
22a. I certify that (1) this hospital attended the deceased from <u>March</u> , 19 <u>81</u> , to <u>Oct 3</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>Oct 3</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		Virginia U. Collins, MD			DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS			10/4/81 1:20				
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL SILVERBROOK CREMATORIAL			23d. LOCATION (City or Town) WILMINGTON		(County)	(State)		
24. FUNERAL DIRECTOR		ADDRESS		25. PSCD BY REGISTRAR			25d. REGISTRAR'S SIGNATURE					
Marvin V. Willing, Jr.		CHESTERTOWN, MD		OCT 8 1981			Frances Jan Wether					
VR A15 (4) 25m-1/70												

1900
John Brown